

Registration under the Health and Social Care Act 2008   
(as amended)

**Application to carry on a new regulated activity**

Application by an existing service provider

**Note: You can also use this form to add a location where   
it will be used to carry on the new regulated activity**

June 2023

**Applications under section 11 of the Health and Social Care Act 2008   
(as amended)**

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| This form must only be used by:  **Existing service providers applying to carry on a new regulated activity**  **It can also be used to add a location where it will be used to carry on the new regulated activity.**  It must not be used by:   * Service providers (‘providers’) that are not yet registered * Providers who want **only** to add a location * Managers, for any purpose |

Registration entitles you to provide ‘regulated activity’ as defined by the Health and Social Care Act 2008 (as amended) (the ‘Act’) and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) (the ‘2014 Regulations’). You can read continuously updated versions of the Act and regulations on our website: www.cqc.org.uk.

**It is an offence under section 10 of the Act to carry on a regulated activity without being registered by the Care Quality Commission (CQC). You could be prosecuted, and it could lead to your application being refused.**

**Fees**

**Before you complete Sections 5 and 6 of this form, you are strongly advised to read the guidance about service types within the Guidance about the Regulations for Providers**

**You should also read our guidance for providers about fees. Both of these documents are available on our website.**

You must check or tick the boxes for the services you will provide at **each** location you are registering. The service types you declare should match the description of your service in your Statement of Purpose. **The service type(s) you select are used to calculate your annual fee**. You can read more information about annual fees on our website.

**Registered managers**

All of the following must have a **registered manager** for the regulated activity:

* Partnerships
* Organisations (excluding NHS bodies in relation to healthcare regulated activities)
* Providers who are individuals who will not be in day-to-day charge of carrying on the regulated activity in this application.

There should normally be a separate registered manager at each location. Managers can sometimes manage more than one regulated activity and/or location (see the relevant guidance on our website).

If any location added in this application already exists, and:

* Is being transferred or sold to you by an existing registered provider, and
* Has an existing registered manager(s) who you intend to employ to manage the same regulated activity (or activities) with the same conditions on their registration at the same location(s),

They can use a ‘fast track’ process that uses a shorter form (‘Application to continue registration as a manager under a new provider’) to both cancel their existing registration and apply for new registration with you as provider.

If you intend any registered managers already working for you to manage the regulated activity in this application, they must submit forms to add (and if necessary remove) regulated activities and/or locations, as needed.

All other managers must submit a full new registered manager application form, even if they are registered as a manager elsewhere or have been in the past.

Managers should download and complete the appropriate forms. The form finder pages on our website will help them to do so. You must submit all required manager’s form(s) with this application.

**Purchase and transfers of existing services and locations**

If this application involves buying or otherwise taking over a service or location(s) being run by an existing registered provider it is important that CQC knows about this. There is space in this form for you to tell us when this is the case; please make sure you complete it where relevant.

CQC must receive and process relevant applications to cancel or vary registration(s) from existing provider(s) and manager(s), as well as from the new provider and manager(s).

New applicants and existing registered persons must work with each other and CQC to ensure that all required applications are submitted. This will ensure the smooth and lawful transfer of legal responsibilities for existing services.

**Confidential personal information**

Please make sure that your application does not include any confidential personal information about the people who will use your service or your staff. This includes any information that can identify a person. We will reject any application form that includes such information.

**Completing this form**

You must provide an answer to every field marked with an asterisk (\*). Other fields are optional but if you have the information please provide it. We will reject an incomplete application and return it to you.

You must complete and submit this form on a computer. Submit it by attaching it to an email; this is the best way to make applications to CQC.

This application form has been prepared as a ‘protected’ Word document. This means that if you use a computer you can easily move from answer to answer using your ‘tab’, down arrow, and page down keys. You can also click from answer to answer using a mouse. You can put an ‘X’ in checkboxes using your space bar or mouse when the box is highlighted. You can go backwards to change your answers using your page up key, up arrow key, or mouse.

Protected Word documents don’t allow you to use the spell check function or to format text with bullet points. If you want to check spelling or use bullet points, type or paste text into a blank new document, correct any spelling errors, add any bullet points, and then copy and paste it into the relevant part of your application form.

You can complete this form on a computer using 'Microsoft Word' or 'Open Office'. Open Office is a free programme you can download from www.openoffice.org. The spaces for answers will expand while you type if needed.

**Additional sections**

Where your application includes **more than one** **existing** or **new location**, you will have to download, complete and submit relevant additional sections of the main form. There is information about this at the relevant places in this form.

Submitting this application by email, you must attach all of the required additional sections and manager application forms, as well as this main form, to your application email.

**If you do not attach an additional location and manager forms *where they are needed,* we will return your application to you.**

We may ask for more information and may carry out a site visit where necessary after you have submitted this form.

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**Section 1: Service provider and the additional regulated activity**

|  |  |
| --- | --- |
| * 1. **Service provider’s details**   † You can find your Provider ID at the top right-hand side of your certificate of registration. | |
| \*CQC Provider ID† |  |
| \*Name of provider |  |
| \*Address line 1 |  |
| \*Postcode |  |

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| **\*1.2 The new regulated activity** | | |
| Please check/tick the new regulated activity you want to carry on  **Please only enter one regulated activity per form, for more than one new regulated activity you will need to complete another form.**  Regulated activities are defined in Regulation 3 of, and Schedule 1 to, the 2014 Regulations. | | |
| Personal care – (RA1) |  |  |
| Accommodation for persons who require nursing or personal care – (RA2) (Please also see Section 5.5 in each location section if you have checked/ticked this activity) |  |  |
| Accommodation for persons who require treatment for substance misuse – (RA3) |  |  |
| Treatment of disease, disorder or injury – (RA5) |  |  |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 – (RA6) |  |  |
| Surgical procedures – (RA7) |  |  |
| Diagnostic and screening procedures – (RA8) |  |  |
| Management of supply of blood and blood derived products – (RA9) |  |  |
| Transport services, triage and medical advice provided remotely - (RA10) |  |  |
| Maternity and midwifery services – (RA11) |  |  |
| Termination of pregnancies – (RA12) |  |  |
| Services in slimming clinics – (RA13) |  |  |
| Nursing care – (RA14) |  |  |
| Family planning service - (RA15) |  |  |

**Section 2: Nominated individuals   
(organisations only, for example, companies, NHS trusts, local authorities and charities)**

**If you are applying as a partnership or as an individual, please go straight to Section 3.**

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| **\*2.1 Nominated individual details** |
| Please provide details of the nominated individual for the new regulated activity (this may be an existing nominated individual). |

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| **\*Details of a nominated individual for a regulated activity** | | | | | | | | | | | | |
| \*Full name | | Title | First | | Middle | | | Last | | | | |
| Previous name (if applicable) | |  | | | | | | | | | | |
| \*Date of birth (dd/mm/yyyy) | |  | | | | | | | | | | |
| \*Business address line 1 | |  | | | | | | | | | | |
| \*Postcode | |  | | | | | | | | | | |
| \*Business Email address | |  | | | | | | | | | | |
| \*Business telephone number | |  | | | | | | | | | | |
| Professional body name | |  | | | | | | | | | | |
| Professional registration number | |  | | | | | | | | | | |
| \* You must ensure that the Nominated Individual is:   * Of good character * Physically and mentally fit to supervise the management of the carrying on of the regulated activity * Has the necessary qualifications, competence, skills and experience to do so, and * Has supplied the registered person with, or arranged for the availability of, the information specified in Schedule 3 to the 2014 Regulations. | | | | | | | | | | | | |
| Have you applied for and received an enhanced Disclosure and Barring Service (DBS) disclosure for the person shown? If you have not done so we will return your application. | | | | | | Yes |  | | No | |  |  |
|  | | | | | | | | | | | | |
| \*DBS disclosure number |  | | | \*Date of disclosure (dd/mm/yyyy) | | | | | |  | | |

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| **\*2.2 Professional body disciplinary proceedings, other investigations, or bars on activity by the Disclosure and Barring Service (DBS)**  Is/has the nominated individual proposed in Section 2.1 been subject to: | | | | | |
| Any safeguarding investigation, criminal investigation or any investigation by a previous employer? | Yes |  | No |  |  |
| Any professional disciplinary action, current proceedings, investigations or restrictions or bars on activity by a health or care professional regulator or the Disclosure and Barring Service? | Yes |  | No |  |  |
| If you have ticked ‘Yes’ to either or both questions, please provide details below. | | | | | |
|  | | | | | |

**Section 3: Application details**

**This section must be completed by ALL applicants**

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| **\*3.1 Statement on meeting the relevant regulations** |
| Please provide a detailed statement on how you will meet the relevant regulations in relation to the new regulated activity you are applying to carry on. (See our guidance on adding a new regulated activity.)  We may ask for further documents and evidence to support this application. |
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| **\*3.2** Readiness |
| You must not begin to provide regulated activity (or activities) at a new location until that location is included in your conditions of registration. Do not Submit this application if your location is not ready to be assessed as this will result in your application being returned. |

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| **\*3.3 Statement of Purpose** |
| The law says that your Statement of Purpose must be up to date. You are changing the details of your registration, so you must send us an amended copy of the Statement of Purpose that covers the locations in this application.  **If you do not, we will return your application.** |

**Section 4: Locations**

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| **\*4.1  Location readiness** | | |
| Is / are the location(s) you will use to carry on the additional regulated activity ready to meet the needs of the people who will use it / them? | | |
| Yes |  |  |
| No |  |  |
| If ‘No’, please describe any building work, conversions, or planning applications that are currently under way, and the date this is expected to be finished. | | |
|  | | |

If you want to carry on the new regulated activity at location(s) that are **already on your certificate of registration**, please now complete **Section 5**.

If you **ONLY** want to carry on the new regulated activity at **new** locations that are **not** shown on your existing certificate of registration, please go straight to **Section 6**.

**Section 5: Existing locations where you want to carry on the new regulated activity**

Please provide details about the services you will provide at relevant locations on your **existing** certificate of registration **if your application to carry on the new regulated activity is granted**.

We need this information because your annual fees are based on the services you provide.

If you are applying to provide the new regulated activity at more than one existing location, you can download additional copies of Section 5 from the website page where you found this form.

Please give each existing location where you will carry on the new regulated activity a number so that we know you have sent us information about all new locations.

**If you don’t give us information about all of these locations we will return your application to you.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **\*5.1 Details for Location number:** | | **1** | **of:** |  | **locations** |
| \*CQC Location ID (if known) |  | | | | |
| \*Name of location |  | | | | |
| \*Address line 1 |  | | | | |
| \*Postcode |  | | | | |
| No of places or beds (\*if applicable) | | | | |  |
| **Day-to-day management of regulated activity at this location** | | | | | |
| Where required, applications for registration from managers in respect of this location, including from *existing* managers to continue their registration to manage it under your registration, must be submitted **with this application**. | | | | | |

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| **\*5.2 All regulated activities you propose to carry on at this location** | | |
| **You cannot apply to carry on a new regulated activity at this location that is not also checked / ticked in Section 1.2, if you wish to apply to carry on two or more NEW regulated activities you must complete an additional form for each regulated activity.** | | |
| Personal care – (RA1) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Accommodation for persons who require nursing or personal care – (RA2) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Accommodation for persons who require treatment for substance misuse (RA3) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Treatment of disease, disorder or injury (RA5) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 (RA6) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Surgical procedures (RA7) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Diagnostic and screening procedures (RA8) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Management of supply of blood and blood-derived products (RA9) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Transport services, triage and medical advice provided remotely (RA10) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Maternity and midwifery services (R11) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Termination of pregnancies (RA12) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Services in slimming clinics (R13) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Nursing care (RA14) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Family planning services (RA15) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |

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| --- | --- |
| **\*5.3 The service types provided at this location** | |
| **Before you complete this section, you are strongly advised to read the guidance about service types that can be found in the ‘Guidance for providers on meeting the regulations’.**  **The service type(s) you select are used to calculate your annual fee, so it is important to select only those that apply to each of the locations you are registering**.  **You should also read our guidance for providers about fees before completing this section.** These guidance documents are available on our website. Please check or tick **ONLY** the service types that will be provided at this location. | |
| **Healthcare services** | |
| **Acute services (ACS)**  If you have checked/ticked this service type, but the only or main activity provided at this location is one of those listed below, please **also check/tick the relevant box**.  If you provide other services at this location as well as Acute services (ACS), or more than one of the activities below at this location, **do not check/tick the boxes below.**   |  |  | | --- | --- | | (a) Haemodialysis or peritoneal dialysis |  | | (b) Dental treatment carried out under general anaesthesia |  | | (c) The termination of pregnancies |  | | (d) Hyperbaric therapy |  | | (e) Refractive eye surgery |  | | (f) Surgical procedures associated with in vitro fertilisation or assisted conception |  | | (g) Obstetric services and, in connection with childbirth, medical services |  | | (h) Cosmetic surgery |  | | (i) Acute services, where the location has no overnight beds for patients |  | |  |
| **Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)** |  |
| **Rehabilitation services (RHS)** |  |
| **Hyperbaric chamber services (HBC)** |  |
| **Hospice services (HPS)**  If you have ticked this service type, please **also** complete **one** of the following questions only:   |  |  | | --- | --- | | (a) Does your hospice service provide overnight beds for patients?  (Please complete even if your service also includes  community or outreach services.) |  | | (b) Does your service provide hospice at home services or end of life or respite care for people in the community? |  | |  |
| **Long-term conditions services (LTC)** |  |
| **Prison health care services (PHS)** |  |
| **Residential substance misuse treatment/rehabilitation services (RSM)** |  |
| **Community or integrated healthcare** | |
| **Community health care services (CHC)**  Please also tick if you are a nursing agency only |  |
| **Doctors consultation services (DCS)** |  |
| **Doctors treatment services (DTS)** |  |
| **Dental services (DEN)**  If this is a single location only please also complete the following question.   |  |  | | --- | --- | | Please state the number of dental chairs at this location  (State ‘0’ if you are a domiciliary dental provider and have no dental chairs of your own) |  |   **Do not complete this question if you are applying to carry on activities at or from more than one location.** |  |
| **Diagnostic and/or screening services (DSS)**  You should **ONLY** tick this service type if diagnostic and/or screening services are the only or main activity you provide at this location. If you provide other services at this location, you should not select this service type, even if you provide the regulated activity of Diagnostic and screening procedures.  **If you have selected DSS, please also complete the following questions:**   |  |  | | --- | --- | | (a) If you are registering as an organisation or a partnership and provide diagnostic and screening services as your sole or main activity, please check/tick this box |  | | (b) If you are registering as an individual, for the regulated activity of Diagnostic and screening procedures ONLY, AND are registering for one location ONLY, please check/tick this box |  | |  |
| **Community-based services for people with a learning disability (LDC)** |  |
| **Mobile doctors services (MBS)** |  |
| **Community-based services for people with mental health needs (MHC)** |  |
| **Community-based services for people who misuse substances (SMC)** |  |
| **Urgent care services (UCS)** |  |
| **Residential social care** | |
| **Specialist college service (SPC)** |  |
| **Care home service with nursing (CHN)** |  |
| **Care home service without nursing (CHS)** |  |
| **Community social care** | |
| **Domiciliary care service (DCC)** |  |
| **Extra Care housing services (EXC)** |  |
| **Shared Lives (SHL)** |  |
| **Supported living service (SLS)** |  |
| **Miscellaneous healthcare** | |
| **Ambulance services (AMB)** |  |
| **Blood and transplant services (BTS)** |  |
| **Remote clinical advice services (RCA)** |  |

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| **For Primary Medical Service providers only**  Please select what type of location this is. | |
| **NHS GP practice** |  |
| **NHS out-of-hours service** |  |
| **Urgent care centre** |  |
| **Minor injury unit** |  |
| **Walk-in centre** |  |
| **Other** |  |
| **Please indicate if this is a dispensing practice** |  |

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| **5.4 Condition of registration about the number of persons accommodated to receive nursing or personal care at this location** | | |
| Only check or tick the box in this section if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 5.2 and either the service type ‘Care home service without nursing’ or ‘Care home service with nursing’ at Section 5.3**. If this does not apply to you go straight to Section 5.6.**  Please check / tick the box below to confirm that you are agreeing in writing to a condition of registration that says:  **“The number of persons accommodated to receive nursing or personal care at this location must not exceed [number].”**  The number in this condition will normally be the one you filled in at Section 5.1 (number of places or beds). We will contact you if we decide we cannot agree to your proposed number for this condition. | | |
| I/We agree in writing to the condition of registration shown above, using the number of places or beds we proposed in Section 5.1 of this form |  |  |

|  |  |  |
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| **5.5 Condition of registration about not providing nursing care at this location** | | |
| Only check / tick the box below if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 5.2 **AND** the service type‘Care home service without nursing (CHS)’ at Section 5.3. **If this does not apply to you please go to Section 5.6.**  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **“The provider must not provide nursing care under the accommodation for persons who require nursing or personal care regulated activity at this location.”** | | |
| I/We agree in writing to the condition of registration shown above |  |  |

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| --- | --- | --- |
| **\*5.6 Condition of registration about the regulated activity (or activities) at this and other locations** | | |
| Please check / tick below to confirm that you are agreeing in writing to a condition of registration in respect of each regulated activity that says:  **“This Regulated Activity may only be carried on at or from the following locations:**  **<First location>**  **<Second location> (if there is one)**  **(and so on for any more locations)”**  The locations in this condition will be those specified in each Section 5.1 submitted with this application. The regulated activities will be the ones you specified in Section 5.2. | | |
| I/We agree in writing to the condition of registration shown above |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*5.7 Service user bands** | | | | | | | | |
| Please look at our [**guidance on service user bands**](https://www.cqc.org.uk/guidance-providers/registration/service-user-bands) before you complete this section.  Please check or tick **all** of the descriptions / service user bands for the people that will use this location. If you will provide a service to everyone you can check or tick “Whole population”.  **Who will use the services at this location?**   General public (all GPs and most primary medical services should select this)  Specific groups (e.g. only people with mental health needs or specific age groups) | | | | | | | | |
| **Age groups** | | | | | | | | |
| Whole population | Children  0 to 3 | Children  4 to 12 | | Children  13 to 17 | | Adults  18 to 65 | Adults  65 + | |
|  |  |  | |  | |  |  | |
| **Service user band** | | | | | | | | |
| Dementia | | |  | | People detained under the Mental Health Act | | |  |
| Mental health | | |  | | People who misuse drugs or alcohol | | |  |
| People with an eating disorder | | |  | | Sensory impairment | | |  |
| Learning disability or autistic spectrum disorder | | |  | | Physical disability | | |  |

|  |  |  |
| --- | --- | --- |
| \***5.8 Condition of registration about providing a specialist service to people with a learning disability or people with a learning disability and autism.** | | |
| [**(See Guidance on agreeing to routine conditions)**](http://www.cqc.org.uk/applicationhelp62)  **This section only applies if you:**   * have applied for **ANY** of the following regulated activities:   + Accommodation for persons who require nursing or personal care   + Personal care   + Assessment or medical treatment for persons detained under the Mental Health Act 1983   **AND**   * have **NOT** selected the service user band of Learning disability or autistic spectrum disorder in section 5.7 above.   **If this does not apply to you, go straight to section 6 below.**  If this location will provide community or residential adult social care services  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for care or support is as a direct result of the person’s learning disability and or autism at or from [this location].’**  If this location will provide in-patient mental health services.  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for assessment or treatment is as a direct result of the person’s learning disability and or autism at or from [this location].’**  Note: We are adding this condition because you will not be providing a specialist service to people with a learning disability or autistic people. Because of this we will not assess your ability to deliver a service in line with [**Right support, right care, right culture**](https://www.cqc.org.uk/guidance-providers/autistic-people-learning-disability/right-support-right-care-right-culture).  If want to provide a specialist service to people with a learning disability or autistic people in the future, you can apply to remove the condition. We must approve your application before you start providing the service. | | |
| We agree in writing to the condition of registration shown above |  |  |

**Important**: Please note if you have not agreed to the condition above because you are intending to provide a specialist service to people with a learning disability and autistic people you will also need to submit an [additional form](https://www.cqc.org.uk/sites/default/files/2022-06/20220504_additional_form_for_providers_of_services_for_autistic_people_and_people_with_%20learning_disabilities.docx) to support your application process.

**Section 6: New locations where you want to carry on the new regulated activity**

**Locations, regulated activities and service types**

Please provide details about the **new** locations where you will carry on the new regulated activity. This means locations that are not on your current certificate of registration. These include new build locations, locations currently carried on by other providers, or locations you are converting from other uses.

If you are applying to provide the new regulated activity at more than one new location, you can download additional copies of Section 6 from the website page where you found this form.

Please give each new location a number so that we know you have sent us information about all of the new locations. If you don’t give us information about all of your locations we will return your application.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **\*6.1 Purchase or transfer of existing location(s)** | | | | | | | |
| Does this application involve the purchase or transfer of location(s) being used by an existing provider that is already registered under the Act? | | Yes |  | No |  | |  |
| If ‘Yes', please fill in the details of the existing registered provider below: | | | | | | | |
| \*CQC provider name |  | | | | | | |
| \*CQC Provider ID |  | | | | | | |
| CQC Location ID |  | | | | | | |
| \*Business/mobile telephone number |  | | | | | | |
| \*Business Email address |  | | | | | | |
| CQC may need to contact the existing provider about this application. Please tick if you do **not** wish CQC to contact the existing provider about this application. **Check/Ticking this box may result in delays to processing your application.** | | | | |  |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **6.2 Details for Location number:** | | **1** | **of:** |  | **locations** |
| \*Name of location |  | | | | |
| CQC Location ID (if Known) |  | | | | |
| \*Address line 1 |  | | | | |
| \*Town/city |  | | | | |
| \*Postcode |  | | | | |
| \*Business/mobile telephone number |  | | | | |
| No of places or beds (\*if applicable) | |  | | | |
| \*Business Email address |  | | | | |
| **Day-to-day management of regulated activity at this location** | | | | | |
| Where required, applications for registration from managers in respect of this location, including from *existing* managers to continue their registration to manage it under your registration, must be submitted **with this application**. | | | | | |

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| **\*6.3 All regulated activities you propose to carry on at this location** | | |
| **You cannot apply to carry on a new regulated activity at this location that is not also checked / ticked in Section 1.2, if you wish to apply to carry on two or more NEW regulated activities you must complete an additional form for each regulated activity.** | | |
| Personal care – (RA1) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Accommodation for persons who require nursing or personal care – (RA2) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Accommodation for persons who require treatment for substance misuse (RA3) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Treatment of disease, disorder or injury (RA5) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 (RA6) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Surgical procedures (RA7) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Diagnostic and screening procedures (RA8) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Management of supply of blood and blood-derived products (RA9) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Transport services, triage and medical advice provided remotely (RA10) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Maternity and midwifery services (R11) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Termination of pregnancies (RA12) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Services in slimming clinics (R13) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Nursing care (RA14) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |
| Family planning services (RA15) |  |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | |

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| **\*6.4 The service types provided at this location** | |
| **Before you complete this section, you are strongly advised to read the guidance about service types that can be found in the Guidance about the Regulations for Providers**  **The service type(s) you select are used to calculate your annual fee, so it is important to select only those that apply to each of the locations you are registering**.  **You should also read our guidance for providers about fees before completing this section.** These guidance documents are available on our website. Please check or tick **ONLY** the service types that will be provided at this location. | |
| **Healthcare services** | |
| **Acute services (ACS)**  If you have checked/ticked this service type, but the only or main activity provided at this location is one of those listed below, please **also check/tick the relevant box**.  If you provide other services at this location as well as Acute services (ACS), or more than one of the activities below at this location, **do not check/tick the boxes below.**   |  |  | | --- | --- | | (a) Haemodialysis or peritoneal dialysis |  | | (b) Dental treatment carried out under general anaesthesia |  | | (c) The termination of pregnancies |  | | (d) Hyperbaric therapy |  | | (e) Refractive eye surgery |  | | (f) Surgical procedures associated with in vitro fertilisation or assisted conception |  | | (g) Obstetric services and, in connection with childbirth, medical services |  | | (h) Cosmetic surgery |  | | (i) Acute services, where the location has no overnight beds for patients |  | |  |
| **Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)** |  |
| **Rehabilitation services (RHS)** |  |
| **Hyperbaric chamber services (HBC)** |  |
| **Hospice services (HPS)**  If you have ticked this service type, please **also** complete **one** of the following questions only:   |  |  | | --- | --- | | (a) Does your hospice service provide overnight beds for patients?  (Please complete even if your service also includes  community or outreach services.) |  | | (b) Does your service provide hospice at home services or end of life or respite care for people in the community? |  | |  |
| **Long-term conditions services (LTC)** |  |
| **Prison health care services (PHS)** |  |
| **Residential substance misuse treatment/rehabilitation services (RSM)** |  |
| **Community or integrated healthcare** | |
| **Community health care services (CHC)**  Please also tick if you are a nursing agency only |  |
| **Doctors consultation services (DCS)** |  |
| **Doctors treatment services (DTS)** |  |
| **Dental services (DEN)**  If this is a single location only please also complete the following question.   |  |  | | --- | --- | | Please state the number of dental chairs at this location  (State ‘0’ if you are a domiciliary dental provider and have no dental chairs of your own) |  |   **Do not complete this question if you are applying to carry on activities at or from more than one location.** |  |
| **Diagnostic and/or screening services (DSS)**  You should **ONLY** tick this service type if diagnostic and/or screening services are the only or main activity you provide at this location. If you provide other services at this location, you should not select this service type, even if you provide the regulated activity of Diagnostic and screening procedures.  **If you have selected DSS, please also complete the following questions:**   |  |  | | --- | --- | | (a) If you are registering as an organisation or a partnership and provide diagnostic and screening services as your sole or main activity, please check/tick this box |  | | (b) If you are registering as an individual, for the regulated activity of Diagnostic and screening procedures ONLY, AND are registering for one location ONLY, please check/tick this box |  | |  |
| **Community-based services for people with a learning disability (LDC)** |  |
| **Mobile doctors services (MBS)** |  |
| **Community-based services for people with mental health needs (MHC)** |  |
| **Community-based services for people who misuse substances (SMC)** |  |
| **Urgent care services (UCS)** |  |
| **Residential social care** | |
| **Specialist college service (SPC)** |  |
| **Care home service with nursing (CHN)** |  |
| **Care home service without nursing (CHS)** |  |
| **Community social care** | |
| **Domiciliary care service (DCC)** |  |
| **Extra Care housing services (EXC)** |  |
| **Shared Lives (SHL)** |  |
| **Supported living service (SLS)** |  |
| **Miscellaneous healthcare** | |
| **Ambulance services (AMB)** |  |
| **Blood and transplant services (BTS)** |  |
| **Remote clinical advice services (RCA)** |  |

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| **For Primary Medical Service providers only**  Please select what type of location this is. | |
| **NHS GP practice** |  |
| **NHS out-of-hours service** |  |
| **Urgent care centre** |  |
| **Minor injury unit** |  |
| **Walk-in centre** |  |
| **Other** |  |
| **Please indicate if this is a dispensing practice** |  |

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| --- | --- | --- |
| **6.5 Condition of registration about the number of persons accommodated to receive nursing or personal care at this location** | | |
| Only check or tick the box in this Section if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 6.3 and either the service type ‘Care home service without nursing’ or ‘Care home service with nursing’ at Section 6.4 above**. If this does not apply to you go straight to Section 6.7.**  Please check / tick the box below to confirm that you are agreeing in writing to a condition of registration that says:  **“The number of persons accommodated to receive nursing or personal care at this location must not exceed [number].”**  The number in this condition will normally be the one you filled in at Section 6.2 above (number of places or beds). We will contact you if we decide we cannot agree to your proposed number for this condition. | | |
| I/We agree in writing to the condition of registration shown above, using the number of places or beds we proposed in Section 6.2 of this form |  |  |

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| **6.6 Condition of registration about not providing nursing care at this location** | | |
| Only check / tick the box below if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 6.3 **AND** the service type‘Care home service without nursing (CHS)’ at Section 6.4. **If this does not apply to you please go to Section 6.7.**  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **“The provider must not provide nursing care under the accommodation for persons who require nursing or personal care regulated activity at this location.”** | | |
| I/We agree in writing to the condition of registration shown above |  |  |

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| **\*6.7 Condition of registration about the regulated activity (or activities) at this and other locations** | | |
| Please check / tick below to confirm that you are agreeing in writing to a condition of registration in respect of each regulated activity that says:  **“This Regulated Activity may only be carried on at or from the following locations:**  **<First location>**  **<Second location> (if there is one)**  **(and so on for any more locations)”**  The locations in this condition will be those specified in each Section 6.2 submitted with this application. The regulated activities will be the ones you specified in Section 6.3. | | |
| I/We agree in writing to the condition of registration shown above |  |  |

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| **\*6.8 Service user bands** | | | | | | | | |
| Please look at our [**guidance on service user bands**](https://www.cqc.org.uk/guidance-providers/registration/service-user-bands) before you complete this section.  Please check or tick **all** of the descriptions / service user bands for the people that will use this location. If you will provide a service to everyone you can check or tick “Whole population”.  **Who will use the services at this location?**   General public (all GPs and most primary medical services should select this)  Specific groups (e.g. only people with mental health needs or specific age groups) | | | | | | | | |
| **Age groups** | | | | | | | | |
| Whole population | Children  0 to 3 | Children  4 to 12 | | Children  13 to 17 | | Adults  18 to 65 | Adults  65 + | |
|  |  |  | |  | |  |  | |
| **Service user band** | | | | | | | | |
| Dementia | | |  | | People detained under the Mental Health Act | | |  |
| Mental health | | |  | | People who misuse drugs or alcohol | | |  |
| People with an eating disorder | | |  | | Sensory impairment | | |  |
| Learning disabilities or autistic spectrum disorder | | |  | | Physical disability | | |  |

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| \***6.9 Condition of registration about providing a specialist service to people with a learning disability or people with a learning disability and autism.** | | |
| [**(See Guidance on agreeing to routine conditions)**](http://www.cqc.org.uk/applicationhelp62)  **This section only applies if you:**   * have applied for **ANY** of the following regulated activities:   + Accommodation for persons who require nursing or personal care   + Personal care   + Assessment or medical treatment for persons detained under the Mental Health Act 1983   **AND**   * have **NOT** selected the service user band of Learning disability or autistic spectrum disorder in section 6.8 above.   **If this does not apply to you, go straight to section 6.10 below.**  If this location will provide community or residential adult social care services  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for care or support is as a direct result of the person’s learning disability and or autism at or from [this location].’**  If this location will provide in-patient mental health services.  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for assessment or treatment is as a direct result of the person’s learning disability and or autism at or from [this location].’**  Note: We are adding this condition because you will not be providing a specialist service to people with a learning disability or autistic people. Because of this we will not assess your ability to deliver a service in line with [**Right support, right care, right culture**](https://www.cqc.org.uk/guidance-providers/autistic-people-learning-disability/right-support-right-care-right-culture).  **If want to provide a specialist service to people with a learning disability or autistic people in the future, you can apply to remove the condition. We must approve your application before you start providing the service.** | | |
| We agree in writing to the condition of registration shown above |  |  |

**Important**: Please note if you have not agreed to the condition above because you are intending to provide a specialist service to people with a learning disability and autistic people you will also need to submit an [additional form](https://www.cqc.org.uk/sites/default/files/2022-06/20220504_additional_form_for_providers_of_services_for_autistic_people_and_people_with_%20learning_disabilities.docx) to support your application process.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*6.10 Planning consent** | | | | | | | | |
| Does this location have planning consent to provide the regulated activity (or activities) you intend to carry on there? | | | | | | | | |
| Yes | |  | No |  | Not applicable | |  |  |
| T | | | | | | | | |
| Local authority |  | | Date of consent received (dd/mm/yyyy) | | |  | |  |
|  | | | | | | | | |
| Where you have indicated **no** or **not applicable** and you do not have planning consent, please explain why it is not needed or why it is not yet received. | | | | | | | | |
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| **\*6.11 Building Regulations** | | | | | | |
| Is there Building Regulations approval for any applicable building works undertaken at this location? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
|  | | | | | | |
| Where you have indicated **no** or **not applicable** and the relevant Building Regulations Certificates have yet to be issued, please tell us when you expect to receive them. | | | | | | |
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| **\*6.12 Safety of equipment, plant and utilities** | | | | | | |
| Do you have maintenance contracts in relation to all the equipment, plant and utilities you own, lease or use – or will own, lease or use – in relation to providing your service in this location? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
| If ‘No’, please describe the equipment, plant and utilities not covered by maintenance contracts and how you will ensure that servicing and repairs are undertaken in a timely and prompt way, as required by their manufacturer’s instructions. | | | | | | |
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| **\*6.13 Landlord/Mortgage lender permission** | | | | | | |
| Where you do not own this location, do you have your landlord’s written permission to use it to carry on the regulated activity (or activities) you intend to provide there?  Where you do not own this location and you have a mortgage, do you have the mortgage lender’s written permission to use it to carry on the regulated activity (or activities) you intend to provide there? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
|  | | | | | | |
| Where you do not have the landlord’s or mortgage lender’s permission, please explain why it is not needed or not yet received. | | | | | | |
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| **\*6.14 Food safety** | | | | | | |
| If you will provide food to the people who use your service at or from this location, have you registered with the relevant local council’s Environmental Health Department as a food business? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
| Where you have not registered with the Environmental Health Department or if you have indicated this is not applicable please explain why. | | | | | | |
|  | | | | | | |

**\*7. How you will provide your service**

**To be completed by ALL applicants (See guidance)**

You must complete each of the five parts of this section of the application. If you do not complete each part we will return your application to you. In answering these five key questions you should demonstrate how the requirements of the Act and associated regulations will be met. In particular the requirements of the 2014 Regulations and the Care Quality Commission (Registration) Regulations 2009 (as amended) (the ‘2009 Regulations’).

|  |
| --- |
| **\*7.1 Please describe how you will ensure your service is safe** |
|  |
| **\*7.2 Please describe how you will ensure your service is effective** |
|  |
| **\*7.3 Please describe how you will ensure your service is caring** |
|  |
| **\*7.4 Please describe how you will ensure your service is responsive** |
|  |
| **\*7.5 Please describe how you will ensure your service is well-led** |
|  |

**\*Section 8: Application declaration**

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| --- |
| **PLEASE READ THE DECLARATION CAREFULLY BEFORE SIGNING**  This is an application under [section 19(1)(a)(b)(c) of the Health and Social Care Act 2008](https://www.legislation.gov.uk/ukpga/2008/14/section/19)  By submitting this application, you confirm:   * you have informed all the relevant parties of this application (for example, directors or partners) * you are authorised to submit this application * you will meet the requirements of the 2009 and 2014 Regulations for each regulated activity that you will carry on at this location   And you understand that:   * it is an offence to make false or misleading statements in this application. If you do so, this application could be refused and you may be liable for prosecution. This is covered under [section 37 of the Act](https://www.legislation.gov.uk/ukpga/2008/14/section/37#:~:text=37False%20statements%20in%20applications&text=%282%29If%2C%20in%20an,is%20guilty%20of%20an%20offence) * it is an offence to carry out any regulated activities without an active CQC registration * you are responsible for all regulated activities until your registration ends   **Privacy**  You understand that the data you have given and other personal data that CQC may obtain, will be used as set out in our [privacy policy.](https://www.cqc.org.uk/about-us/our-policies/privacy-statement)  The person who signs below must be one of the following, for a/an:  **Organisation:** Any individual authorised to do so by the Organisation  **Partnership:** A registered member of the partnership  **Individual:** The individual |

|  |  |
| --- | --- |
| Please check or tick this box to confirm that the appropriate number of registered managers have also submitted applications for registration |  |
| I/we confirm that I/we understand and accept this declaration |  |

We will accept a typed-in name as a signature.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \* Authorised signatory |  | | | |
| \* Authorised signatory full name | Title | First | Middle | Last |
| \*Date of signing (dd/mm/yyyy)  (Do not enter your date of birth) |  | | | |
| \*Role / job title |  | | | |
| \*Business Email address |  | | | |

**How to submit this application and accompanying documents**

Please submit this application via email to CQC, making sure that all required additional forms and documents are included.

**Failure to submit all required additional forms will result in your application being returned.**

The checklist below lists the documents that you need to include with your application**.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Form or document** | | | | **Done** |
| Statement of Purpose | **Failure to submit an updated Statement of Purpose will result in your application be returned.** | | |  |
| Additional EXISTING location sections as needed | Number of EXISTING locations where I/we will carry on the new regulated activity |  |  |  |
|  |
|  |
| Number of additional existing location sections submitted with this application |  |  |
|  |
|  |
| Additional NEW location sections as needed | Number of NEW locations where I/we will carry on the new regulated activity |  |  |  |
|  |
|  |
| Number of additional new location sections submitted with this application |  |  |
|  |
|  |
| Registered manager application forms  (where relevant) | Number of locations that will have a manager |  |  |  |
|  |
|  |
| Number of manager application forms (of all types) submitted with this application |  |  |
|  |
|  |

**Where to send your application:**

You should **email** completed form(s) and all required accompanying documents to:

[**HSCA\_Applications@cqc.org.uk**](mailto:HSCA_Applications@cqc.org.uk)

You must attach all forms and documents to the same email.

If you do not submit all required forms and information your application will be returned to you.

You can read more information on our website [www.cqc.org.uk](http://www.cqc.org.uk) or call our National Customer Service Centre on **03000 616161**.

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